

**ACCIDENT/INJURY INVESTIGATION REPORT**

*Section I of this form must be completed within 24 hours of* ***all*** *occupational injuries, illnesses, or accidents involving ER/St James Mercy Hospital’s temporary or full-time employees and submitted to Human Resources*

*Retain this form in the branch OSHA/Workers' Compensation file for five years from the date of the incident or five years after the workers' compensation claim is closed,* ***whichever is longer. Form is equivalent to OSHA's form 301.***

*Section I – ACCIDENT/INJURY INVESTIGATION REPORT*

*Completed by Employee with Manager/Supervisor:*

DIRECTIONS: If employee needs URGENT medical care, please obtain the written statement as soon as possible following treatment. Please write clearly. FORM MUST CONTAIN THE EMPLOYEE’S SIGNATURE.

EMPLOYEE Full NAME: \_\_\_\_\_

Injured employee’s job title: \_\_\_\_\_

Department: \_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Date Hired\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Male\_\_\_\_ Female\_\_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TIME EMPLOYEE STARTED WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPROXIMATE TIME OF INJURY: \_\_\_\_\_\_\_\_\_\_\_

Was the Employee treated in an Emergency room? [ ]  Yes [ ]  No

If yes, please describe the type of treatment received:

 \_\_\_\_\_

 \_\_\_\_\_

 Name of facility where it was provided:

Physician or other health care professional \_\_\_\_\_

Was Employee hospitalized overnight as an in-patient? [ ]  Yes [ ]  No

Did the injury/illness result in lost time or restricted duty? [ ]  Yes [ ]  No

If yes, please describe: \_\_\_\_\_

 \_\_\_\_\_

***Section I - ACCIDENT/INJURY INVESTIGATION REPORT*** *cont’*

*Completed by Employee with Manager/Supervisor:*

WHEN DID YOU FIRST REPORT THIS, AND TO WHOM WAS IT REPORTED? \_\_\_\_\_

 \_\_\_\_\_

IF YOU DID NOT REPORT THIS IMMEDIATELY WHEN IT OCCURRED, PLEASE EXPLAIN WHY: \_\_\_\_\_

 \_\_\_\_\_

WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? \_\_\_\_\_

 \_\_\_\_\_

WHAT HAPPENED?

DESCRIBE EXACTLY HOW THIS INJURY OCCURRED: \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

WHAT WAS THE INJURY OR ILLNESS ( tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain" or "sore"):

 \_\_\_\_\_

 \_\_\_\_\_

What Object or substance directly harmed the employee?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARK THE AREA ON THE ILLUSTRATION BELOW WHERE YOU ARE

HAVING THE SYMPTOMS YOU DESCRIBED ON THE INJURY REPORT

 

   

[ ] PALM SIDE [ ] TOP OF FOOT

[ ] BACK SIDE [ ] BOTTOM OF FOOT

\*Note: Please attach photographs, drawings, statements, and any additional data to report.

Date: Employee Signature (Required): \_\_\_\_\_

***Section I - ACCIDENT/INJURY INVESTIGATION REPORT*** *cont’*

*Completed by Employee with Manager/Supervisor:*

WAS A SAFETY DEVICE REQUIRED? [ ]  YES [ ]  NO

WERE YOU TRAINED PROPERLY ON HOW TO USE THE SAFETY DEVICE? [ ]  YES [ ]  NO

DID YOU USE THE SAFETY DEVICE? [ ]  YES [ ]  NO

IF APPLICABLE, WHAT SAFETY DEVICE WAS REQUIRED AND/OR USED? \_\_\_\_\_

 \_\_\_\_\_

HAVE YOU EVER EXPERIENCED THE SAME OR SIMILAR SYMPTOMS DESCRIBED ABOVE, OR HAD A PRIOR INJURY TO THE SAME PART OF YOUR BODY? [ ]  YES [ ]  NO

*This information allows us to determine your pre-existing status. This does not disqualify you from being entitled to care for any current injury or any aggravation to an underlying pre-existing condition. It is in your best interest to provide this information at the time of injury.*

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

WHO WAS YOUR MEDICAL TREATMENT PROVIDER FOR THIS PRIOR CONDITION/INJURY? \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

APPROXIMATELY WHEN DID THIS PRIOR TREATMENT OR INJURY TAKE PLACE? \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

I understand that this statement will be considered part of the investigation process and that I may be called upon to testify or provide written or verbal clarifying statements. The statement I have provided is an accurate account of the case to the best of my knowledge.

Date: Employee Signature (Required): \_\_\_\_\_

***Section I - ACCIDENT/INJURY INVESTIGATION REPORT cont’***

*Completed by Employee with Manager/Supervisor:*

| Contributing Factors |
| --- |
| Check all contributing factors to the accident in the boxes below. |
| Injury and Property Damage[ ]  Distraction[ ]  Failure to secure (locking, tightening, closing)[ ]  Failure to use personal protective equipment[ ]  Failure to warn (signs, barricades, alarms)[ ]  Horseplay[ ]  Improper activation[ ]  Improper body mechanics[ ]  Improper loading[ ]  Improper placement[ ]  Improper position for task[ ]  Improper safety equipment[ ]  Making safety devices inoperable[ ]  Operating equipment without authority[ ]  Operating at improper speed (hurrying, speeding)[ ]  Removing safety devices[ ]  Servicing equipment in operation/no lockout[ ]  Unsafe driving[ ]  Using defective equipment[ ]  Using equipment improperly[ ]  Under influence of drugs or alcohol[ ]  Confined space entry (tanks or vessels)[ ]  Congested or restricted area/activity [ ]  Defective tools, equipment, or materials[ ]  Excessive noise[ ]  Explosion[ ]  Fire[ ]  Hazardous environmental conditions (spills, gases, dusts, smokes, fumes, vapors)[ ]  Hazardous personal attire[ ]  High or low temperature exposure[ ]  Icy conditions[ ]  Inadequate guards or barriers[ ]  Inadequate lighting[ ]  Inadequate protective equipment[ ]  Inadequate ventilation[ ]  Inadequate warning system (alarms, barricades, signs)[ ]  Poor housekeeping; disorder[ ]  Projecting hazard (pole, angle iron, etc.)[ ]  Pinch point (gears, pulleys, belts, etc.)[ ]  Road conditions[ ]  Safety device inoperable[ ]  Slippery conditions[ ]  Hazardous storage/stacking[ ]  Other (explain):       | Vehicle Accident[ ]  Following too closely[ ]  Improper turning[ ]  Improper backing[ ]  Improper lane change[ ]  No/improper pre-trip[ ]  Left of center[ ]  Failure to secure equipment[ ]  Improper use of mirrors[ ]  Improper use of turn signals[ ]  Improper use of lights[ ]  Improper use of horn[ ]  Improper use of emergency equipment[ ]  Misjudged clearance[ ]  Failed to yield right of way[ ]  Alcohol - under influence[ ]  Drugs - under influence[ ]  Disregarding traffic signals/signs[ ]  Unsafe speed for conditions[ ]  Improper passing[ ]  Obstructing traffic[ ]  Improper load[ ]  Failure to use safety equipment[ ]  Improper parking[ ]  Defective brakes[ ]  Worn/smooth tires[ ]  Defective lights (vehicle)[ ]  Inadequate lighting (roadway)[ ]  Defective windshield wipers[ ]  Defective steering mechanism[ ]  Road construction[ ]  Loose road surface materials[ ]  Holes/ruts in road[ ]  Standing water[ ]  Defective equipment tools[ ]  Icy road conditions[ ]  Wet road conditions[ ]  Inclement weather[ ]  Parked/stopped vehicle[ ]  Overloaded vehicle[ ]  Obstruction to view (signs, trees, buildings., etc.)[ ]  Glare[ ]  Fog[ ]  Smoke[ ]  Other (explain):       |
| Provide details for all contributing factors checked above.      |

*Section II – ACCIDENT/INJURY INVESTIGATION REPORT*

*Completed by witnesses and/or co-workers:*

CO-EMPLOYEE/WITNESS STATEMENT

DIRECTIONS: Please write clearly. FORM MUST CONTAIN THE SIGNATURE OF THE PARTY SUPPLYING THE STATEMENT. Make copies if additional statements are required.

STATEMENT REGARDING: \_\_\_\_\_ (name of injured employee)

WITNESS NAME: \_\_\_\_\_

WITNESS JOB TITLE: \_\_\_\_\_

WHAT IS YOUR KNOWLEDGE REGARDING THIS INJURY: \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

(USE BACK OF FORM IF NECESSARY)

PLEASE LIST ANY OTHER WITNESSES OR INDIVIDUALS THAT MAY HAVE INFORMATION RELATIVE TO THIS INVESTIGATION: \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

I understand that this statement will be considered part of the official investigation and that I may be called upon to testify or provide written or verbal clarifying statements. The statement I have provided is an accurate account of the case to the best of my knowledge.

Date: Signature (Required): \_\_\_\_\_

Phone: Home Address: \_\_\_\_\_

*Section III – ACCIDENT/INJURY INVESTIGATION REPORT*

*Completed by Employee with Manager/Supervisor:*

|  |
| --- |
| Root Causes |
| Check all applicable causal factors (root cause) that, if corrected, would prevent recurrence of the same or similar injury/illness, accident, or near miss. |
| Personal Factors [ ]  Improper work habits[ ]  Lack of knowledge[ ]  Lack of skill[ ]  Physical limitations[ ]  Pre-existing condition | Job Factors |
| [ ]  Abuse or misuse[ ]  Improper equipment/tool design[ ]  Inadequate engineering[ ]  Inadequate leadership/supervision[ ]  Inadequate maintenance[ ]  Inadequate purchasing standards[ ]  Inadequate training | [ ]  Inadequate work procedures[ ]  Overtime[ ]  Promotional (sales)[ ]  Unusual work load[ ]  Wear and tear[ ]  Not employee’s regular occupation[ ]  Not employee’s regular work hours |
| Provide details for all root causes checked above.      |

|  |
| --- |
| Corrective Action Plan |
| Check all actions needed to eliminate recurrence of the same or similar accident. |
| Change Procedures | Change Behavior | Make Work Improvements |
| [ ]  Modify housekeeping procedures[ ]  Develop safer work procedures[ ]  Eliminate unsafe activity procedures [ ]  Communicate job procedures[ ]  Review employee skills relating to job[ ]  Review/improve maintenance of tools/equipment[ ]  Redesign work process[ ]  Require additional training/orientation[ ]  Other       | [ ]  Prevent/correct employees bypassing safety devices[ ]  Prevent/correct operation of unsafe equipment[ ]  Act to enforce use of protective equipment[ ]  Act to prevent/correct unsafe speed or improper operation[ ]  Act to prevent/correct employee doing unsafe work[ ]  Correct the disregard of unsafe work conditions[ ]  Enforce/use correct safety procedure[ ]  Act to prevent on premise intoxication/other[ ]  Take action to address general health problem[ ]  Take disciplinary action[ ]  Other       | [ ]  Modify design of work station[ ]  Modify lighting[ ]  Modify ventilation[ ]  Modify flow of materials[ ]  Provide better tools and equipment[ ]  Replace defective equipment[ ]  Safeguard against failure of safety devices[ ]  Prevent/alleviate unguarded hazard[ ]  Prevent/alleviate crowded conditions[ ]  Prevent/alleviate slippery/wet conditions[ ]  Take actions to prevent blind corners[ ]  Prevent/alleviate unsafe conditions/acts[ ]  Other       |
| Provide details for all corrective actions checked above. |
| No. | Description of Corrective Action | Assigned To | Completion Date |
| 1. |       |       |       |
| 2. |       |       |       |
| 3. |       |       |       |
| Investigating Supervisor's Signature | Date:      |

|  |
| --- |
| Risk |
| If this accident went uncorrected and happened again, how severe would it be? [ ]  Major [ ]  Serious [ ]  Minor  | If this accident went uncorrected and happened again, what is the probability it would reoccur? [ ]  Frequent [ ]  Occasional [ ]  Seldom |

|  |
| --- |
| Investigation Conducted by: |
| Name      | Title      |
| Signature | Date      |

Arrange meeting with Accident Investigation Committee for further review: [ ]